STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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KAUHALE PORT CITY SPECIALTY CARE	4720 MORRISON DRIVE MOBILE, AL 36609

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments On November 13, 2025, an unannounced inspection of care survey was conducted for this 20 bed Specialty Care Assisted Living Facility (SCALF) with 17 residents. There were no complaints investigated during this survey. There were deficiencies written as a result of the inspection of care investigation. Deficiencies were cited during the survey for failure to operate in accordance with the Rules of the Alabama State Board of Health (SBOH), Alabama Department of Public Health (ADPH), Chapter 420-5-20, Alabama Administrative Code, Specialty Care Assisted Living Facilities. Deficiencies cited resulted in harm for one resident and put all residents at risk for significant harm.	A 000		
A 301	420-5-20-.03 (1) (a) (b) (c) (d) Administration. (1) The Specialty Care Assisted Living Facility Governing Authority. (a) A specialty care assisted living facility shall have an identified sole proprietorship, corporation, partnership, limited partnership, or other business entity that is its governing authority, or it shall have a designated individual or group of designated individuals who serve as its governing authority. A facility must give complete information to the Department identifying: 1. Each person who has an ownership interest of 10 percent or more of the governing authority. 2. Each person or entity who has an	A 301		

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ownership interest of 10 percent or more in the real property or building used by the specialty care assisted living facility to offer its services.

3. Each officer and each director of the corporation if the governing authority is a corporation.

4. Each partner, including any limited partners, if the governing authority is a partnership.

(b) The governing authority shall submit any changes to the information listed above to the Department within 15 days of the change.

(c) Responsibility of Staff to Governing Authority. The administrator, medical staff, facility personnel, and all auxiliary organizations shall be directly or indirectly responsible to the governing authority. For the purposes of these rules, auxiliary organizations include but are not limited to licensed or certified outside providers, consultants, management companies that are not the facility license holder.

(d) The governing authority is responsible for appointing and supervising the administrator who is responsible for overall management and the day-to-day operation of the facility. Under no circumstances shall the facility operate without a licensed administrator for greater than 45 days.

This Rule is not met as evidenced by:
Based on observation, record review and interview, the Governing Authority failed to provide adequate support and proper oversight to

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the facility to ensure the facility achieved and maintained compliance with state specific rules and regulations regarding the RN (Registered Nurse) duties and resident health supervision. This deficient practice resulted in actual harm for one resident and placed all 17 residents at significant risk for harm.

THIS IS A REPEAT DEFICIENCY THAT WAS CITED DURING THE SURVEY COMPLETED MAY 26, 2021.

Findings:

On November 6, 2025, the Alabama Department of Public Health received a facility reported incident which alleged a resident of the facility had taken medications that belonged to another resident and then expressed suicidal ideations. An investigation of care survey was conducted to ascertain the care and safety of residents.

At the time the surveyor entered the facility on November 11, 2025, Employee Identifier (EI)#2 had been the administrator since September 1, 2025. EI#2's past work experience included administrative duties. EI#2 reported EI#1, the Senior Director of Operations, had provided training in the areas of staffing and census, but no clinical orientation for the day-to-day operations of the facility had been provided. EI#2 said no one in the Governing Authority had been on-site to train her since she started work on September 1, 2025. EI#11, the Clinical Operations Regional Director, acknowledged she had not been on-site since EI#2 was hired.

The investigation of care survey revealed EI#3, the RN/Wellness Director, facilitated the admission of a resident that did not meet criteria

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for admission to a SCALF. A physician's order was not followed to keep Resident Identifier (RI)#1 from hazardous items. EI#3 facilitated psychoactive/anti-anxiety medications to be used to address acute behaviors. Medications administered by EI#3 were not documented contemporaneously. General observation was not provided for RI#1 which resulted in actual harm to the resident. Staffing that was scheduled by EI#3 did not meet the minimum requirements for a SCALF. RI#1's care plan was not updated regarding behaviors even when said behaviors were present on admission. EI#3 either inaccurately assessed or failed to conduct required admission assessments. EI#3 failed to ensure physicians' orders were obtained for residents to have medications at the bedside.

In addition, EI#3, RN, forged the signature of the facility's medical director on a prescription for a psychoactive/anti-anxiety medication. The anti-psychotic medication was used to medicate RI#1 during an episode of acute behavior which is against the SBOH rules. During an interview with the surveyor about RI#1's preadmission assessment performed by EI#3, EI#3 said she had spoken with nurses at the local hospital, RI#1's spouse and a hospital nurse practioner (NP). EI#3 even described the entryway of the hospital and gave a detailed description of the location of the security guard. However, EI#3 eventually admitted to the surveyor that she had not been truthful. She (EI#3) at no time went to the hospital to assess RI#1. EI#3 conducted the assessment via FaceTime and never spoke to hospital staff nurses or the nurse practitioner on site at the hospital.

EI#3 did not follow facility policies and procedures. Refer to deficiencies 302, 401, 504,

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A 301	Continued From page 4 508, 601, 604, 605, 607, 608, 611, 612, 613, 615, and 620 for additional information regarding EI#3's failure to perform her duties. On the afternoon of November 12, 2025, EI#2 provided the History and Physical (H&P) from RI#1's hospital stay prior to admission to the facility. EI#2 had reviewed the report and said, "Here is the H&P from (RI#1's) stay at (names hospital). It doesn't look good. Suicidal and homicidal ideations. The admission not only put (RI#1) at risk, but the other residents and staff as well." NOTE: On the afternoon of November 13, 2025, EI#2, informed the surveyor that EI#1 had instructed her (EI#2) to have EI#3, the Registered Nurse (RN)/Wellness Director, removed from the premises prior to the exit interview with the surveyor. The following deficient practices were cited during the onsite survey due to a lack of management and oversight of the facility, particularly the facility RN, by the governing authority. 302 - The facility failed to implement its own policies and procedures. 401 - The facility was not staffed with at least the minimum required staff at all times. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON APRIL 3, 2025 405 - The facility Registered Nurse (RN) and Care Coordinator duties were not performed consistently to ensure the facility operated in compliance with SBOH rules for SCALFs. 504 - The facility failed to provide a safe	A 301		

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A 301	Continued From page 5 environment for residents at all times. 508 - The facility failed to identify a reported incident as an attempted suicide, failed to conduct a complete investigation of the event and did not take actions that would prevent recurrence. 601 - The facility failed to follow physicians' orders to keep hazardous items from a resident. 604 - The facility failed failed to ensure the accuracy of the pre-admission assessment and completion of other required assessments. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON NOVEMBER 5, 2019 605 - The facility failed to utilize general observation and health supervision of a resident. 607 - The facility staff delayed notification of 911 during a medical emergency that could have resulted in death, serious medical impairment or disability of the resident. 608 - The facility treated a resident who exhibited emergency behavioral symptoms with an anti-anxiety medication. 611 - The facility failed to develop a plan of care which contained interventions to meet the care and safety needs of a resident with suicidal ideations, homicidal ideations and safety risks identified in the initial physicians' medical examination. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON APRIL 3, 2025 612 - The facility failed to develop a specific	A 301		

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A 301	Continued From page 6 activity program to meet the needs of a resident who had wandering behaviors. 613 - The facility failed to obtain a physician's order for a resident to manage or have custody of his/her medication. 619 - The facility failed to ensure stored medical supplies were inspected annually to ensure their usability. 620 - The facility admitted a resident that did not meet admission criteria requirements for a SCALF. Preceding Survey History The plan of correction accepted on April 24, 2025 for the survey conducted on April 3, 2025, documented "... the Executive Director and/or Memory Care Director, RN (EI#3) will retrain all staff on the State Regulations for staffing requirements in the SCALF to ensure there are at least 3 associates in the SCALF on all 3 shifts/7 days per week. ..." Refer to deficiency 401 Furthermore, this same plan of correction, also documented, "Effective immediately, the Memory Care Director, RN, will begin using the Care Plan Addendum template to capture all pertinent medical information. ..." Neither of these proposed plans of corrections were in place at the time of this survey.	A 301		
A 302	420-5-20-.03 (e) Administration. (e) Policies. The governing authority shall be responsible for establishing and implementing written policies for the management and operation of the facility and shall be responsible for development of, and	A 302		

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A 302	Continued From page 7 adherence to, procedures implementing those policies. The policies and procedures shall be made available to residents, any guardians, next of kin, sponsoring agency(ies), or representative payee(s). All residents shall be informed of new policies or changes in existing policies that may have bearing on the resident. All residents shall be provided a copy of such policies at least 30 days prior to the policies taking effect. Policies shall cover the following: (i) Facility responsibility to protect all residents from abuse, neglect, and exploitation. (ii) How allegations of abuse, neglect, and exploitation will be handled by the facility. (iii) Resident confidentiality. (iv) Admission and continued stay criteria. (v) Discharge criteria and notification procedures for residents and sponsors. (vi) Facility responsibility when a resident's personal belongings are lost. (vii) What services the facility is capable and not capable of providing. (viii) Medication management. (ix) Infection control. (x) Meal service, timing, menus and food preparation, storage, and handling. (xi) Fire safety and emergency plan, fire	A 302		

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A 302	Continued From page 8 drills, fire alarm system, sprinkler and fire extinguisher checks, and disaster preparedness. (xii) Staffing and conduct of staff while on duty. (xiii) Oxygen administration and storage if used in the facility. (xiv) Dietary Policies. The dietitian, with the approval of the administrator, shall develop written policies and procedures for the guidance of all personnel handling food as outlined by the most current Food and Drug Administration Food Code published by the U.S. Department of Health and Human Services. The facility shall develop and implement dietary policies and procedures to meet the needs of the residents in the facility. In addition to other matters deemed necessary by the facility, dietary policies shall address: (I) Sanitation of dishes, utensils, and service equipment, and sanitary food preparation and handling. (II) The attire and cleanliness of staff members who prepare, handle, or serve food. (III) A schedule of meals, which shall include between-meal nourishment or snacks, and fluids. (IV) Food substitutions or alternatives. (V) Method to ensure an adequate dietary plan is implemented for any resident with a therapeutic diet or special dietary needs.	A 302		

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A 302	Continued From page 9 (VI) Procedure to be followed if a resident is nutritionally compromised or is not eating adequate quantities of food. (VII) Provision of necessary services to any resident requiring adaptive devices to eat. (VIII) Procedure for the handling of potentially hazardous foods such as meat, milk, ice, and eggs. (IX) Storage of food. (X) Procedure for food service in the event of a disaster. Disaster menus shall be developed. The policy shall address how food will be obtained and maintained at safe temperatures if electricity is not available. This Rule is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow its own policies and procedures for management and operation of the facility. Findings: A facility policy titled, "Care Plan Policy" revealed, "... Assisted Living & Specialty Care Assisted Living (Memory Care) 1. Purpose The purpose of this policy is to ensure that every resident ... receives individualized, comprehensive, and regularly updated care planning in compliance with Alabama Administrative Code 420-5-4 ... Definitions Care Plan: A written, individualized plan of care developed from the resident's assessment. Assessment: Comprehensive evaluation of physical, cognitive, emotional,	A 302		

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medical, behavioral, and functional status. ... 4. Policy Statement (Name of facility) will maintain current, individualized, and comprehensive care plans for all residents ... before admission (SCALF) ... 5. Care Plan Requirements (Alabama-Specific) ... Care plans will address ADLs (Activities of Daily Living), medical needs, behavior, cognition, risks, preferences, and interventions. ...6. Development of the Care Plan Care plans must be developed by the RN in collaboration with the resident, family, caregivers, life enrichment, dining, and other departments, based on assessments, provider documents, behavior history, and observations. ..." Refer to deficiencies 405, 504, 604 and 611 for additional information.

Review of a facility provided caregiver notification revealed, "ATTENTION ALL RESIDENT CARE GIVERS Although all caregivers are expected to know and understand the Notification of Change policy, there are times when a resident may vary from their baseline behavior/condition, that would warrant you to call 911 and send the resident to the hospital. The following are conditions that would justify calling 911. ... unusual behavior ..." Refer to deficiency 607 for additional information.

Review of a policy titled, "Policy Name: Staffing Requirements," revealed, "... MEMORY CARE ... staffing is based on resident need as per the requirements in the table below: Table A ... Staff ... 3 (number of required staff) 7 AM - 3 PM ... Residents ... 17 - 24 ... 3 PM - 11 PM ... Residents ... 17 - 36 ... 11 PM - 7 AM ... Residents ... 17 - 48 ..." Note a minimum of 3 staff members were required each shift for the seventeen resident residing on this memory care unit. Refer to deficiency 401 for additional information.

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A 302	Continued From page 11 Review of a policy titled, "Policy Name: SCALF Pre-Admission Requirements - Alabama ... Applies to: Memory Care Policy Overview Per Alabama state regulation, residents shall be screened and approved prior to admission to the Specialty Care Assisted Living Facility. This screening shall include a clinical history, RN Comprehensive Assessment, PSMS (Physical Self Maintenance Scale), Behavior Screen and a mental status examination consisting of a mini-mental, aphasia screening, and a geriatric depression screen. Each resident shall be carefully evaluated by an RN and the Executive Director. ..." Refer to deficiencies 604 and 620 for additional information. Review of a policy titled, "Policy Name: New Resident Admission ... Staff Actions When a resident who is new to the Memory Care setting is having difficulty with adjustment and/or is displaying exit seeking behaviors, staff will consult the resident's Care Plan Addendum for specific interests and individualized interventions for the resident. The Clinical Director will document the occurrences of adjustment issues and exit seeking behaviors in the resident Care Plan Addendum. ... In the case of a resident who remains in the building, continues to demonstrate these behaviors ... Staff should not leave the resident alone. Assign one person to be with resident until a plan for safety has been developed. ..." Refer to deficiencies 405, 504, 605, 607, 608 and 612 for additional information. Review of a policy titled, "Policy Name: Admission/Discharge Criteria Policy ... Applies to: Memory Care-AL(Alabama)/SCALF ... Policy Detail 1. Admission Criteria. An individual must meet the following minimum criteria in order to be	A 302		

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A 302	Continued From page 12 admitted into the community: ... c) Is not combative, violent, suicidal, or homicidal. ... e) Cannot exhibit behaviors that are unmanageable ... m) Has undergone a mental status examination consisting of aphasia screening, a geriatric depression screen, a physical self-maintenance screen, mini mental and a behavior screen, as well as an RN Comp (Comprehensive) and Medical History. ..." Refer to deficiencies 604 and 620 for additional information.	A 302		
A 401	420-5-20-.04 (1) (2) Personnel. (1) A specialty care assisted living facility shall ensure adequate personnel are employed and on duty to meet the care and safety needs of all residents 24 hours a day, 7 days a week. No specialty care assisted living facility shall have fewer staff on duty than specified in Table A below. Even if this minimum staffing ratio is met, the governing authority of a specialty care assisted living facility shall have additional staff on duty to meet the care and safety needs of all residents 24 hours a day, 7 days a week. Facilities with resident bedroom wings separated from the remainder of the facility by a lockable door shall maintain dedicated staff to these areas adequate to meet all care and safety needs of the residents in these areas at all times. Table A Staff Number 7 AM - 3 PM 3 PM - 11 PM 11 PM - 7 AM 2 1 -16 Residents 1 - 16 Residents 1 - 16 Residents 3 17 - 24 Residents 17 - 36	A 401		

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Residents 17 - 48 Residents
4 25 - 32 Resident 37 - 48
Residents 49 - 64 Residents
5 33 - 40 Residents 49 - 60
Residents 65 - 80 Residents
6 41 - 48 Residents 61 - 72
Residents 81 - 96 Residents
7 49 - 56 Residents 73 - 84
Residents 97 - 112 Residents
8 57 - 64 Residents 85 - 96
Residents 113 - 128 Residents
9 65 - 72 Residents 97 - 108
Residents 129 - 144 Residents
10 73 - 80 Residents 109 - 120
Residents 145 - 160 Residents
11 81 - 88 Residents 120 - 132
Residents 161 - 176 Residents

1 Additional Staff For each 8 residents, or any fraction thereof, by which the census exceeds 88 For each 12 residents, or any fraction thereof, by which the census exceeds 132 For each 16 residents, or any fraction thereof, by which the census exceeds 176

(a) A specialty care assisted living facility shall be staffed at all times by at least one individual who has a current certification in cardiopulmonary resuscitation (CPR).

(b) A specialty care assisted living facility must be sufficiently staffed to ensure the safe evacuation of all residents in the event of a fire or emergency.

(2) Employee Schedule. A specialty care assisted living facility shall post a schedule of

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A 401	Continued From page 14 employees indicating names and days and hours scheduled to work. This schedule shall be retained in the facility for 6 months after use. In the event of an unplanned staff shortage which would make it otherwise impossible to meet the staffing requirements imposed by these rules, a facility may employ a certified nurse aide who has not received the training specified in these rules. For the purposes of this subsection, a certified nurse aide is defined as an individual who has been deemed or determined to be competent by the Alabama Nurse Aide Registry maintained by the Alabama Department of Public Health. This individual may not work unless accompanied at all times by an individual who is appropriately trained in accordance with these rules. Such employment shall last only until the facility has employed staff trained in accordance with the above. In no event may the period during which such staff is employed in a facility exceed 120 consecutive hours. This Rule is not met as evidenced by: Based on document review and interview, the facility was not staffed with at least the minimum required staff at all times. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON APRIL 3, 2025. Findings: At the time of the onsite survey from November 11-13, 2025, the census of the facility was 17. The census required no less than three staff	A 401		

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A 401	Continued From page 15 members to be on duty from the hours of 11:00 PM - 7:00 AM. A review of the schedule revealed a nurse and two caregivers were scheduled for each 11:00 PM - 7:00 AM shift. However, staff reported the nurse would medicate residents in the ALF and if there was a fall, blood glucose issue or an assessment needed in the ALF, the SCALF nurse would leave the SCALF unit. On the afternoon of November 11, 2025, EI#3, said to the surveyor, "Will you teach me the reg (regulation) on staffing?" This surveyor responded, "If you know and follow the rule, why would you need me to teach you?" EI#3 responded, "We follow the rule, but if management pushes us to cut staffing, I need to have something to push back (with)." On the afternoon of November 12,2025, EI#13, an RN who works the 11:00 PM-7:00 AM shift on the SCALF unit, reported she also leaves the SCALF to pass medications in the ALF. The Medication Administration Records (MARs) for two residents were reviewed and confirmed EI#13 was administering medication for the ALF unit while scheduled to work on the SCALF unit. Later that afternoon of November 12, 2025, EI#14, a Licensed Practical Nurse (LPN), said she goes back and forth from SCALF to ALF. EI#14 said she had argued with EI#3 about doing so. If a resident in the ALF had a fall, wanted Tylenol or was feeling sick she had to leave the SCALF unit to take care of the ALF residents. EI#14 also reported she had medicated the same two ALF residents which the surveyor confirmed by reviewing the MARs. On the afternoon of November 13, 2025, EI#3, RN, said she was the person who scheduled	A 401		

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A 401	Continued From page 16 staff. EI#3 added that during the 11:00 PM-7:00 AM shift the nurse gives medications to two resident in the ALF unit. EI#3 was asked about the same deficiency being cited during the April 2025, survey. EI#3 claimed she did not know that the nurse could not leave the SCALF to give medications in the ALF unit. Note: The plan of correction accepted on April 24, 2025, for the survey conducted on April 3, 2025, documented "... the Executive Director and/or Memory Care Director, RN (EI#3) will retrain all staff on the State Regulations for staffing requirements in the SCALF to ensure there are at least 3 associates in the SCALF on all 3 shifts/7 days per week. ..." Later on the afternoon of November 13, 2025, EI#2 was asked why designated staff for the SCALF were having to leave the unit to pass medications in the ALF. EI#2 said she did not know but the procedure was already in place when she arrived at the facility. EI#2 said it was on the list of many things she was trying to correct.	A 401		
A 405	420-5-20-.04 (6) (7) (8) Personnel. (6) Medical Director. Each specialty care assisted living facility shall have a medical director who is a physician currently licensed to practice medicine in Alabama. The medical director is responsible for implementation of resident care policies, and the coordination of medical care in the facility. The medical director shall participate in quality assurance activities in the facility. A nurse practitioner or physician's assistant shall not serve as the medical director of a specialty care assisted living facility.	A 405		

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A 405	Continued From page 17 (7) Registered Professional Nurse. Each facility shall have at least one RN. An RN may also serve as the administrator or as the care coordinator, but not as both. In all instances where the facility's RN is assigned other duties as an administrator or care coordinator the facility must assure that the RN devotes sufficient time and effort to all clinical duties. (a) Responsibility. The RN shall be responsible for oversite and coordination of resident care. 1. The RN shall assess the residents in the specialty care assisted living facility. 2. The RN shall develop, document, and evaluate resident plans of care. 3. The RN shall consult with the administrator on all issues of resident safety, health, and wellbeing. 4. The RN shall communicate significant resident changes to the resident's physician and sponsor or responsible family member. 5. The RN shall identify staff training needs and ensure needed training is appropriately provided. 6. The RN shall direct the practice of any licensed practical nurse. (8) Care Coordinator. There shall be a care coordinator who will manage the daily routine delivery of resident care. This person shall be an LPN or RN. An LPN care coordinator shall	A 405		

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A 405	Continued From page 18 work under the supervision of the RN in the management and delivery of resident care. This Rule is not met as evidenced by: Based on interview and record review, the facility RN and Care Coordinator duties were not performed consistently to ensure the facility operated in compliance with SBOH rules for SCALFs. THIS DEFICIENCY WAS CITED AS A RESULT OF AN INVESTIGATION OF CARE SURVEY. Findings: On November 6, 2025, the Alabama Department of Public Health received a facility self reported incident which alleged a resident of the facility had taken medications that belonged to another resident and expressed suicidal ideations. An investigation of care survey was conducted to ascertain the care and safety of residents. Review of resident records on November 11-13, 2025 revealed, RI#1 was admitted to the facility on November 3, 2025. The discharge summary from the local hospital documented diagnoses to include dementia, seizure disorder, hypertension, history of stroke, diabetes mellitus, a history of alcohol abuse and suicidal and homicidal ideations. At the time of the pre-admission screening, conducted by EI#3 via FaceTime, RI#1 was a patient of a local hospital after having been admitted for suicidal and homicidal ideations. However, EI#3 ignored the above discharge summary and documented in the facility pre-admission screen that the resident was not suicidal, the resident did not exhibit behaviors	A 405		

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harmful to self or others, and that the resident was not combative, resistive to care or violent. In addition, EI#3 documented the resident did not have a history of alcohol abuse and there had been no change in mood or behavior in the last six months. EI#3 documented in the behavior screen that the resident was not disruptive/loud, was not demanding or verbally aggressive and was not destructive to self or property.

The clinical history and admission diagnosis of RI#1 listed above was confirmed on the afternoon of November 12, 2025, by EI#12, the Director of Clinical Compliance (at the hospital). EI#12 reported RI#1 was brought in through their emergency department by the police. RI#1 was on suicide precautions until discharged to the facility. According to EI#12, during EI#3's FaceTime interview with RI#1, RI#1 was still at the local hospital, with around-the-clock sitters and the curtains in the hospital room had been removed to prevent RI#1 from harming himself/herself.

EI#3 documented on the RN COMPREHENSIVE ASSESSMENT that vital signs were within normal limits and breath sounds were audible in all quadrants during this FaceTime call which is impossible via a FaceTime call. The following required pre-admission screenings were noted by EI#3 as resident refused, therefore RI#1 was not assessed properly as required by the SBOH rules with a completed mental status examination, aphasia screening and geriatric depression screening. Of the two questions answered out of thirty questions on the geriatric depression screening, one question asked, "Are you basically satisfied with your life?". EI#3 documented the answer "NO". This is notable due to the fact RI#1 had been admitted to the hospital for suicidal and

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A 405	Continued From page 20 homicidal ideations. The clinical history that was required to be part of the admission screening was located in the discharge summary from the hospital and read partially as follows: "... Admit (Admission) date: 10/26/2025 Discharge Date: 11/3/2025 ... Admission Information ... who presents with acute agitation and confusion with suicidal and homicidal ideation. See admission H&P (History and Physical) for further information. ... Hospital Course Primary diagnosis Dementia ... Consult services: Psychiatry ... (refers to RI#1) with advanced dementia and complex neurological history ... and history of alcohol dependence presented with agitation with suicidal and homicidal ideation. Patient was recently discharged from a (an) inpatient rehabilitation center, upon returning home, patient had frequent episodes of agitation, confusion, paranoia with comments consistent with suicidal and homicidal ideation. Patient's behavior raised significant concern from family members who called 911 and patient was transported to (name of hospital) for further evaluation. Psychiatry was consulted during admission and they recommended continual one-to-one observation given patient's mental status ... During admission patient continued to have episodes of agitation, confusion and paranoia requiring close observation. ... Discharge Diagnoses Aggressive behavior ... Psychiatric symptoms ... Patient's mood remains labile with episodic outburst of anger and agitation. Nursing staff reports episodes of paranoia (in) which patient becomes very agitated with nursing staff ... History and Physical ... Unsafe discharge Complex Disposition Primary reason for admission, patient refused to go home and (spouse) states he/she cannot safely manage (RI#1) ..." On November 3, 2025, the day RI#1 was	A 405		

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admitted to the facility, RI#1 was taking Seroquel 25 milligrams (MG) at bedtime for behaviors. EI#3 requested an additional 25 MG of Seroquel every morning and Haloperidol 0.5 MG every six hours as needed for agitation. On November 5, 2025, the day before RI#1 overdosed, EI#3 had requested the bedtime dose of Seroquel to be increased to 50 MG.

On the morning of November 13, 2025, EI#10, the Medical Director, reviewed the signed orders for the medications requested by EI#3. EI#10 said they were not signed by him and gave signature examples. EI#10 said he had never seen that signature before nor had he seen the prescription for Haldol. EI#10 acknowledged Haldol was not appropriate to prescribe to treat emergency behaviors based on SCALF regulations. EI#10 said he was not given any information about RI#1's behaviors. EI#10 said he was not made aware RI#1 was hospitalized after police were called for suicidal and homicidal ideations or that RI#1 required one to one observation for suicide potential. EI#1 said he was only showed one of two pages of the physician's medical examination by EI#3. The page he was shown did not contain the behavior portion with instructions to keep the resident from hazardous items. EI#10 said if EI#3 had made him aware that RI#1 had been on suicide watch, he would have said RI#1 was not appropriate for admission.

There was inadequate management of the daily routine delivery of resident care by the RN/Wellness Director. EI#3 facilitated the admission of a resident that did not meet criteria for admission to a SCALF. A physician's order was not followed to keep RI#1 from hazardous items. EI#3 facilitated psychoactive/anti-anxiety

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medications to be used to address acute behaviors. Activities were insufficient to meet the care needs of a resident with wandering behaviors. MARs indicated medications administered by EI#3 were not documented contemporaneously. Incidents were not accurately reported to the ADPH as required and were not investigated. General observation was not provided for RI#1 which resulted in actual harm. Staffing did not meet the minimum requirements for a SCALF. A resident's plan of care did not address behaviors to include suicidal and homicidal ideations. EI#3 either inaccurately assessed or failed to conduct required admission assessments. EI#3 failed to ensure physicians' orders were obtained for residents to have medications at the bedside. EI#3 forged the signature of the Medical Director for a psychoactive/anti-anxiety medication. EI#3 did not follow facility policies and procedures. EI#3 did not ensure covid test kits were not expired. Refer to deficiencies 302, 401, 504, 508, 601, 604, 605, 607, 608, 611, 612, 613, 615, 619 and 620 for additional information regarding EI#3's failure to perform her duties.

On the afternoon of November 11, 2025, EI#3 said to the surveyor, "Will you teach me the reg (regulation) on staffing?" This surveyor responded, "If you know and follow the rule, why would you need me to teach you?" EI#3 responded We follow the rule, but if management pushes us to cut staffing, I need to have something to push back (with)." Later that afternoon, when asked about RI#1's clinical history, EI#3 said she had spoken with nurses and RI#1's spouse. When EI#3 was asked how she obtained RI#1's clinical history, EI#3 repeated that she had spoken with nurses at the hospital, RI#1's spouse and a hospital nurse

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practioner (NP). EI#3 even described the entryway of the hospital and gave a detailed description of the location of the security guard. However, EI#3 eventually admitted to the surveyor that she had not been truthful. She (EI#3) at no time went to the hospital to assess RI#1. EI#3 conducted the assessment via FaceTime and never spoke to hospital staff nurses or the nurse practitioner on site at the hospital. When EI#3 was asked what "harmful substances" on RI#1's medical examination (exam) meant, she answered she took that as poisons and sharp objects. When EI#3 was asked if the Propranolol pills were harmful to RI#1, she said, "Well yes." EI#3 failed to prevent lancets (sharp objects) and Propranolol from being available in residents' room.

On the morning of November 12, 2025, the spouse of RI#1 was interviewed. RI#1's spouse reported EI#3 was fully aware of RI#1's mental health issues including suicidal and homicidal ideations that escalated in early 2024. RI#1's spouse added unfortunately EI#3 was not on-site to interview RI#1, because she (EI#3) conducted the admission assessment via FaceTime. RI#1's spouse said at the time of the FaceTime assessment, RI#1 was still on suicide watch, with a sitter in the room during the interview. Sitters were with RI#1 around-the-clock and curtains had been removed from RI#1's room as there was a potential for harm while at the hospital. RI#1's spouse had been told RI#1 was on a rampage the night before he/she took the pills and was pulling things off the walls, going in residents' rooms and making a scene in front of other residents.

On the afternoon of November 12, 2025, EI#2, the Administrator, provided the History and

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Physical (H&P) from the hospital stay prior to admission to the facility. EI#2 had reviewed the report. EI#2 said, "Here is the H&P from (RI#1's) stay at (names hospital). It doesn't look good. Suicidal and homicidal ideations. The admission not only put (RI#1) at risk, but the other residents and staff as well."

On the afternoon of November 13, 2025, EI#3 had initially said she went to the hospital, interviewed the resident, nurses and a nurse practioner (NP). EI#3 was asked why she lied about going to the hospital when she had only FaceTimed the resident. EI#3 said, "That day I was pulled really thin and I was trying to stretch even more. They were looking for placement quickly. But mostly I was spread to thin. EI#3 said, "I did not interview the NP or nurses." EI#3 was asked again why she lied about going to the hospital for RI#1's assessment. EI#3 said. "I didn't want to disappoint anyone. I knew I would have to tell you the truth." EI#3 said the handwriting on the order for the Haldol was hers. EI#3 said the signature on the Haldol order was EI#10's. A few minutes after the conclusion of this interview, EI#3 returned to the conference room and admitted, "I signed (EI#10's) name after I got the order. I wanted to get it here for (RI#1). I shouldn't have, but I did. What do I do now?" EI#3 reported she had informed EI#10 that she had forged his signature.

On the afternoon of November 13, 2025, the surveyor discussed these findings with EI#1, EI#2 and EI#11, the Clinical Operations leader. They each were aware of the egregiousness of the failures that resulted in significant harm for RI#1 and declared the issues would be addressed.

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A 504	Continued From page 25	A 504		
A 504	420-5-20-.05 (3) (d) Records and Reports. (d) Residents' Rights. Each resident shall be fully informed, prior to or at the time of admission, of these rights. A copy of these rights shall be conspicuously posted in a resident common area. Each resident's file shall contain a copy of a written acknowledgment that he or she has read these rights, or has had these rights fully explained by facility staff to the resident, or, if appropriate, to the resident's sponsor. The acknowledgment shall be signed and dated by the administrator or the administrator's designee and by the resident or sponsor, when appropriate. 1. No resident shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law or the Constitution of the U.S. solely by reason of status as a resident of the facility. 2. Every resident shall have the right to live in a safe and decent environment, to be free from abuse, neglect, and exploitation, and to be free from chemical and physical restraints. 3. Every resident shall have the right to be treated with consideration, respect, and due recognition of personal dignity, individuality, and the need for privacy. 4. Every resident shall have the right to unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any reasonable time. 5. Every resident shall have freedom to	A 504		

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participate in and benefit from social, religious, and community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community.

6. Every resident shall have the right to manage his or her own financial affairs. If a resident or his or her legally appointed guardian authorizes the administrator of the facility to provide a safe place to keep funds on the premises, an individual account record for each resident shall be maintained by the administrator and an up-to-date record shall be maintained for all transactions.

7. Every resident shall have the right to share a room with his spouse if both are residents of the facility and agree to do so.

8. Every resident shall have the right to a reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals.

9. Every resident shall have the right to exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor compulsory attendance at religious services, shall be imposed upon any resident.

10. Every resident shall have access to adequate and appropriate health care consistent with established and recognized standards within the community including the right to receive or reject medical care, dental care, or other health care services except those required to control communicable diseases.

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A 504	Continued From page 27 11. Every resident shall have the right to at least 30 days prior written notice of involuntary relocation or termination of residence from the facility unless the resident is a patient in a facility providing a higher level of care and no longer meets the eligibility and continued stay requirements in these rules, or for medical reasons the resident is considered by a physician to require an emergency relocation to a facility providing a more skilled level of care, or unless the resident engages in a pattern of conduct that is harmful or dangerous to himself or herself or to other residents. Such actions will be documented in the resident's admission record. 12. Every resident shall have the right to present grievances and recommend changes in policies, procedures, and services to the staff of the facility, the facility's management and governing authority, and to any other person without restraint, interference, coercion, discrimination, or reprisal. 13. Every resident shall have the right to confidential treatment of personal and medical records. A resident may authorize the release of records to any individual of his or her choice. Such authorization must be given by the resident in writing and the written authorization must be included in the resident's file. 14. Every resident shall have the right to refuse to perform work or services for the facility unless the resident expressly agrees to perform such work or services and this agreement is plainly documented in the admission agreement. A resident may voluntarily perform work or services for the facility, provided that:	A 504		

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A 504	Continued From page 28 (i) The facility has documented the resident's desire to perform work in the resident's plan of care, and the resident has signed this plan of care. (ii) The plan of care specifies the nature of the work to be performed and sets forth the compensation to be paid for the service, unless the service is to be performed without compensation. (iii) The resident has the right and understands that he or she has the right to terminate the agreement to work at any time without recourse. 15. Every resident shall be fully informed, prior to or at the time of admission and at regular intervals during his or her stay, of services available in the facility, and of related charges. 16. Every resident shall be fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission, of all rules and regulations governing residents' conduct and responsibilities. 17. Every resident shall have the right to have the name, telephone number, and address of the Department's Bureau of Health Provider Standards, the Local Ombudsman, the Department of Human Resources, and the telephone numbers of the Department of Public Health toll-free Assisted Living Facilities Complaint Hotline and the Department of Human Resources toll-free Elder Abuse Hotline. All of this information shall be posted in a conspicuous location in a resident common area.	A 504		

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A 504	Continued From page 29 18. All state inspection reports and any resulting corrective action plan from the past 24 months shall be posted in a prominent location. If there has been no inspection in the past 24 months, then the results of the most recent inspection and any resulting corrective action plan shall be posted. 19. Every resident shall have the right to 30 days prior written notice to both resident and sponsor of any increase of fees or charges. 20. Every resident shall have the right to 30 days prior written notice of any involuntary change in the resident's room or roommate unless the change is necessary because the resident or the resident's roommate engages in a pattern of conduct that is harmful or dangerous to himself or herself or to other residents. 21. Every resident shall have the right to wear his or her own clothes, and to keep and use his or her own personal possessions, including toilet articles, except for personal possessions too large to be stored in the resident's room. 22. Every resident shall have the right to be afforded privacy for sleeping and for storage of personal belongings. 23. Every resident shall have the right to have free access to day rooms, dining, and other group living or common areas at reasonable hours. 24. Every resident shall have the right to participate in devising the resident's care plan, including providing for the resident's preferences	A 504		

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A 504	Continued From page 30 for physician, hospital, nursing home, acquisition of medication, emergency plans, Advance Directives, and funeral arrangements. A copy of this care plan shall be kept in the resident's file. This Rule is not met as evidenced by: Based on record review, observation and interview, the facility failed to provide a safe and decent environment for residents at all times which resulted in actual harm for one resident and placed all 17 residents at significant risk for harm. THIS IS A REPEAT DEFICIENCY THAT WAS CITED DURING THE SURVEY COMPLETED APRIL 3, 2025. Findings: On November 6, 2025, the Alabama Department of Public Health received a facility reported incident which alleged a resident of the facility had taken medications that belonged to another resident and said, "I want to die." An investigation of care survey was conducted to ascertain the care and safety of residents. During the survey, widespread deficient practices were discovered which jeopardized the safety and wellbeing of residents. The facility was not staffed at all times by at least the minimum required number of staff. (Deficiency 401) The facility RN and Care Coordinator duties were not performed consistently to ensure the facility operated in compliance with SBOH rules for SCALFs. (Deficiency 405) The facility failed to identify a reported incident as an attempted suicide, failed to conduct a complete investigation of the event,	A 504		

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A 504	Continued From page 31	A 504		

indicated a resident was conscious with normal vital signs when the resident was neither and did not take actions that would prevent recurrence. (Deficiency 508) The facility failed to follow physicians' orders to keep hazardous items from a resident. Also, a prescription for an anti-psychotic medication was forged by the RN. (Deficiency 601) The facility failed to ensure the accuracy of the pre-admission assessment and completion of other required assessments which resulted in the admission of a resident with suicidal and homicidal ideations, who attempted suicide after less than three days at the facility. (Deficiency 604) The facility failed to utilize general observation and health supervision of a resident that attempted suicide which resulted in significant harm. (Deficiency 605) The facility staff delayed notification of 911 in the event of a medical emergency that resulted in serious harm and could have resulted in death, serious medical impairment or disability of the resident. (Deficiency 607) The facility treated a resident that was admitted directly from a hospital stay that provided for around the clock one-on-one sitters who exhibited emergency behavioral symptoms with an anti-anxiety medication. (Deficiency 608) The facility failed to develop a plan of care which contained interventions to meet the care and safety needs of a resident with suicidal ideations, homicidal ideations and safety risks identified in the initial physicians' medical examination. (Deficiency 611) The facility failed to develop a specific activity program to meet the needs of a resident who had wandering behaviors that escalated prior to a suicide attempt. (Deficiency 612) The facility admitted a resident that had been admitted to the hospital for suicidal and homicidal ideations and who was on suicide watch with around the clock one-on-one sitters. Indicating the resident was at risk for harm to self

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A 504	Continued From page 32 or others and did not meet admission criteria requirements for a SCALF. (Deficiency 620) The failure to provide safety and decency in the facility resulted in significant harm for one resident and placed all 17 residents at significant risk of harm.	A 504		
A 508	420-5-20-.05 (3) (h) Records and Reports. (h) Incident Investigation. When an incident, as defined below, occurs in a specialty care assisted living facility, the facility administrator shall be immediately notified, the facility shall conduct a thorough investigation, and appropriate corrective actions and interventions shall be devised and implemented immediately. A detailed and accurate report shall be completed within 72 hours of the incident. The report shall be given immediately upon completion to the administrator for review. 1. Incidents which require investigation are: (i) An accident or injury of known or unknown origin that was unusual or suspicious in nature such as extensive bruising, pain, or injury that is not consistent with actions necessary in providing day-to-day care to a resident or for which medical treatment was sought. (ii) A fracture or an injury resulting in medical attention. For the purposes of these rules, medical attention shall be defined as care that rises above the level of first aid including but not limited to a physician ordered portable X-ray, a visit to an emergency department, urgent care facility, clinic or physician office.	A 508		

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A 508	Continued From page 33 (iii) The onset of wandering behavior by any resident who is not fully cognitively intact. (iv) Elopement by a resident. (v) Suspected, alleged, confessed, witnessed, or actual abuse of a resident or residents by staff, visitors, or other residents. This includes all types of abuse including mental abuse, physical abuse, sexual abuse, and verbal abuse as defined in these rules. (vi) Suspected, alleged, confessed, witnessed, or actual neglect of a resident or residents as defined in these rules. (vii) Suspected, alleged, confessed, witnessed, or actual exploitation of a resident or residents as defined in these rules. (viii) An outbreak (for purposes of these rules, an outbreak is considered to be two or more affected people within 72 hours or less) of a contagious disease or condition including those listed in Appendix I to Alabama Administrative Code Sec. 420-4-1-.04 (for example food-borne illness, scabies, influenza, or Staphylococcus aureus). (ix) A fire, earthquake, storm, other act of God, or other occurrence (for example, a natural gas leak or a bomb threat) that causes physical damage to the building in which the facility is located, or that results in the evacuation or partial evacuation of the facility. (x) Intentional self-inflicted injury, suicide, or suicide attempt by a resident.	A 508		

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A 508	Continued From page 34 (xi) An unplanned occurrence that results in media attention. (xii) A medication error, overdose, or over sedation. (xiii) Ingestion by a resident of a toxic substance that requires medical attention. (xiv) Any indication of malfunction of the sprinkler system, or fire alarm system. 2. In addition to other items required by the facility's policies and procedures, the incident investigation shall contain the following: (i) Names of all residents involved. (ii) Names of all staff involved including person in charge at the time of the incident. (iii) When the administrator was notified (date and time). (iv) Circumstances under which the incident occurred. (v) When the incident occurred (date and time). (vi) Where the incident occurred (for example, bathroom, bedroom, street, or lawn). (vii) Immediate actions taken. (viii) The extent and description of injury, if any, to the affected resident or residents.	A 508		

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A 508	Continued From page 35 (ix) Immediate treatment rendered. (x) Symptoms, pain, or injury discussed with the physician, and the date and time the physician was notified. (xi) Names, telephone numbers, and addresses of witnesses. (xii) Date and time relatives or sponsor were notified. (xiii) Out-of-facility treatment. (xiv) Follow-up care. (xv) Outcome resolution. (xvi) The action taken by the facility to prevent the occurrence of similar incidents in the future. (xvii) The investigative file includes the incident report itself, the incident investigation and all records, documents, statements, images, and information created or reviewed in connection with the investigation. (xviii) The entire investigative file shall be made available for inspection and copying by representatives of the Department upon request. (xix) The entire investigative file and documentation of all corrective action taken shall be retained for a period of not less than 3 years after the resident is discharged or dies. (xx) Interventions devised as a result of the investigation shall be included in a resident	A 508		

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A 508	Continued From page 36 record that is available to the personal care staff. 3. In addition, the following incidents shall be reported to the Department's Online Incident Reporting System within 24 hours of the incident: (i) A fracture or an injury resulting in death, EMS activation, or the need for medical attention. (ii) Elopement by a resident. (iii) Suspected, alleged, confessed, witnessed, or actual abuse, neglect, or exploitation of a resident or residents. This includes all types of abuse including mental abuse, physical abuse, sexual abuse, and verbal abuse as defined in these rules. The victim's sponsor or responsible family member shall be notified within 24 hours. All incidents of suspected abuse, neglect, or exploitation shall be reported immediately to the Department of Human Resources or to appropriate law enforcement authorities as required by law. These documents shall be retained with the facility investigative file. (iv) A fire, earthquake, storm, other act of God, or other occurrence (for example, a natural gas leak or a bomb threat) that causes physical damage to the building in which the facility is located, or that results in the evacuation or partial evacuation of the facility. (v) Intentional self-inflicted injury, suicide, or suicide attempt by a resident. (vi) An unplanned occurrence that results in media attention.	A 508		

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A 508	Continued From page 37 (vii) Any medication error, overdose, or over sedation. The incident shall be immediately reported to the attending physician, facility medical director, or back-up physician. (viii) Ingestion by a resident of a toxic substance that requires medical attention. (ix) Notifiable diseases and health conditions listed in Appendix I to Alabama Administrative Code Sec. 420-4-1-.04. shall also be reported by the facility to the State Health Officer or the County Health Officer within the time frames specified in 420-4-1-.04. The facility shall maintain documentation of any reports of notifiable diseases or health conditions. This documentation shall be retained for a period of not less than three years. (x) Any indication of a malfunction of the sprinkler system, fire alarm system, or a door locking device. 4. The report to the Department's Online Incident Reporting System shall include the following: (i) Facility name and direct phone number. (ii) Time and date of the report. (iii) Reporter's name. (iv) Name of resident(s), staff, or visitor(s) involved in the incident. (v) Names of staff on duty at the time of	A 508		

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A 508	Continued From page 38 the incident. (vi) Date and time of the incident. (vii) A brief description of the incident. (viii) Any injury or injuries to resident(s). (ix) Action taken by the facility in response to the incident. (i) Vital Statistics Reports. A record shall be kept of all births, deaths, and stillbirths that occur within the specialty care assisted living facility. By the fifth day of each month, the administrator shall make a report of such births, deaths, and stillbirths for the preceding month on such forms as the State Board of Health shall provide to the county health officer, or in counties without a county health officer, to the State Registrar. This report shall be in addition to the official birth, death, and stillbirth certificates. If there are no births, deaths, or stillbirths in any month, a report shall be made stating that fact to the county health officer. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to identify a reported incident as an attempted suicide, failed to conduct a complete investigation of the event and failed to take actions that would prevent recurrence. THIS IS A REPEAT DEFICIENCY THAT WAS CITED DURING THE SURVEY COMPLETED	A 508		

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A 508	Continued From page 39 APRIL 3, 2025. Findings: On November 6, 2025, the Alabama Department of Public Health received a facility reported incident which alleged a resident had taken medications that belonged to another resident and said, "I want to die." The reported incident was not identified as a self-inflicted intentional injury. Instead, the report was submitted as a fracture or injury resulting in EMS activation. Review of the investigation provided by the facility included witness statements but no interviews to question how a resident took approximately two-thirds of a bottle of Propranolol to try to commit suicide. The investigation erroneously said that emergency services were notified at 8:00 AM. Also, the reported incident documented the resident was conscious and vital signs were within normal limits. That information contradicts the run report obtained from the local EMS (Emergency Management System). EMS paramedics documented the resident was unconscious and RI#1's blood pressure was 56/37. The determination of the root cause did not identify that the resident had been admitted directly from a hospital where he/she was on suicide watch. The facility did not include actions taken to prevent recurrence of similar incidents in the future. Refer to deficiencies 302, 405, 504, 508, 601, 604, 605, 607, 608, 611, 612, 615 and 620 for additional information regarding RI#1. On the afternoon of November 13, 2025, EI#3 said she was responsible for ensuring incident investigations were completed and accurate. EI#3 said her investigation included getting witness statements from EI#4 and EI#5 but she did not think about EI#6, the other caregiver that was on	A 508		

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A 508	Continued From page 40 duty at the time of the attempted suicide. EI#3 was asked why she did not interview the witnesses. EI#3 said, "I thought (EI#2) was doing it and we were in a state of shock. I take responsibility." Later on the afternoon of November 13, 2025, EI#2 said she and EI#3 were both responsible for ensuring incident investigations were complete and accurate, but ultimately she was.	A 508		
A 601	420-5-20-.06 (1) Care of Residents. (1) Medical Direction and Supervision. The medical care of residents shall be under the direction and supervision of a physician. (a) Designation of Attending Physician. Upon admission, each resident shall be asked to designate an attending physician of his or her choice. If the resident is unable to designate an attending physician, or does not wish to designate an attending physician, the facility shall assist the resident in identifying an attending physician who will serve the resident. A resident shall be permitted to change the designation of his or her attending physician at any time. Whenever a resident requires medical attention, an attempt shall first be made to contact the resident's attending physician, except in medical emergencies requiring activation of the local EMS system (911 or other emergency call). (b) Back-up Physician Support. Each specialty care assisted living facility shall have an agreement with one or more duly licensed physicians to serve in those instances when a resident's own attending physician cannot be reached, and to provide temporary medical attention to any resident whose attending	A 601		

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A 601	Continued From page 41 physician is temporarily not available. A nurse practitioner or physician's assistant shall not serve as the back-up physician in a specialty care assisted living facility. (c) All physician orders shall be written in accordance with community standards. If verbal orders are used, they are to be used infrequently. A physician verbal order shall only be accepted by an RN or LPN employed by the facility and authorized to do so by facility policy and procedures and state law. All verbal orders shall be reduced to writing on the physicians' order sheet by a licensed facility nurse and shall be dated and signed by the nurse receiving the order. All orders, including verbal orders, shall be dated, timed, and authenticated promptly by the ordering practitioner, or another practitioner who is responsible for the care of the resident and authorized to write orders by facility policy. All verbal orders must be authenticated within such time period as provided by facility policy, but in no case shall exceed 30 days following entry of the order. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to follow physicians' orders to keep hazardous items from a resident. Also, a physician's order was not written in accordance with community standards. THIS DEFICIENCY WAS CITED AS A RESULT OF AN INVESTIGATION OF CARE SURVEY. Findings: RI#1 was admitted to the facility on November 3,	A 601		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAUHALE PORT CITY SPECIALTY CARE	4720 MORRISON DRIVE MOBILE, AL 36609

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 601	Continued From page 42 2025. Refer to deficiencies 302, 405, 504, 508, 601, 604, 605, 607, 608, 611, 612, 615 and 620 for additional information regarding RI#1. Review of resident records on November 11-13, 2025, revealed the following information. Physician's orders were not followed: A review of the Physician's Medical Examination for RI#1 dated October 30, 2025, revealed, "... Behaviors: redirection/provide safety ... Safety: keep away from hazardous items ..." Observations made during a tour of the facility on the morning of November 11, 2025, included: lancets (sharp tools with needle tips used for finger punctures), medicated creams, medicated powders, disinfectant spray and electric razors. Physician's order not written in accordance with community standards: A review of RI#1's order revealed that on November 3, 2025, the day RI#1 was admitted to the facility, RI#1 was taking Seroquel 25 milligrams (MG) at bedtime for behaviors. EI#3 requested an additional 25 MG of Seroquel every morning and Haloperidol 0.5 MG every six hours as needed for agitation on the day of admission. On November 5, 2025, the day before RI#1 overdosed, EI#3 had requested the bedtime dose of Seroquel to be increased to 50 MG. Initially, EI#3, RN, said EI#10 had signed the order for the Haloperidol, but later admitted she had forged EI#10's signature. On the morning of November 13, 2025, EI#10, reviewed the signed orders for the medications requested by EI#3. EI#10 said they were not signed by him and gave signature examples. EI#10 said he had never seen that signature before or the prescription for Haldol. EI#10	A 601		

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A 601	Continued From page 43 acknowledged Haldol was not appropriate to prescribe to treat emergency behaviors according to the SBOH rules. On the afternoon of November 13, 2025, EI#3 said she had forgotten that anti-psychotic and anti-anxiety medications could not be used as a first resort. EI#3 acknowledged she should not have forged EI#10's signature. Later on November 13, 2025, EI#2 said the concern of forged psychoactive drug prescriptions was that it was illegal.	A 601		
A 604	420-5-20-.06 (3) (a) (b) (c) (d) (e) Care of Residents. (3) Health Supervision. (a) Initial Assessment. No more than 30 days prior to admission, the facility RN or care coordinator shall screen prospective residents for eligibility for admission into the specialty care assisted living facility. The screening shall include a clinical history, a mental status examination to include aphasia screening, a geriatric depression screen, a physical self-maintenance screen, and a behavior screen. Appendix A herein, contains the Physical Self Maintenance Scale (PSMS) form and the Behavior Screening form. These forms shall be completed to screen physical functioning and behaviors. The PSMS and Behavior Screen assessments shall be completed by the RN or care coordinator upon admission, annually, and when there is a change in the resident's status. The facility RN shall perform a comprehensive assessment of each prospective	A 604		

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A 604	Continued From page 44	A 604		

resident for facility eligibility. This assessment shall document identified care needs and serve as a baseline for the RN plan of care and future assessments.

(b) Monthly Assessments. The RN shall assess each resident monthly and more often when necessary to identify changes in the resident's health status. The monthly assessment shall include a review of monthly weights, falls, incidents, elopements, behavioral symptoms, medications, changes in resident status, and appropriateness of the resident's plan of care.

(c) Comprehensive Assessment. The facility RN shall perform a comprehensive assessment and communicate with the resident's attending physician and with the resident's sponsor or responsible family member when a decline in health status or behavior occurs, or if the resident develops any of the following problems:

1. Weight loss:

(i) Each month, the facility shall accurately weigh and record the weight of each resident.

(ii) A significant weight loss is defined as a five percent or greater weight loss in a period of one month or less, or a seven and a half percent or greater weight loss in a period of 3 months or less, or a 10 percent or greater weight loss in a period of 6 months or less. Any weight loss shall be considered to be an unplanned weight loss unless the affected resident has been placed on a restricted calorie diet specifically for the purpose of reducing the resident's weight, and

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A 604	Continued From page 45 such diet has been approved by the resident's attending physician. 2. Falls (two or more falls within a 30 day period). 3. Elopement. 4. Any sign and symptom of adverse drug reaction, interaction or over sedation, or circumstances which contraindicate medications that have been prescribed for the resident. 5. Unmanageable, combative, or potentially harmful behavior(s). 6. Any accident with injury. (d) Focused Assessments. The RN or LPN shall conduct focused assessments when necessary to identify changes in resident status. (e) Any change in resident status requires immediate documentation and implementation of interventions or reassessment of existing interventions. This Rule is not met as evidenced by: Based on record review and interview, the facility RN, EI#3, failed to perform her duties to ensure the safety and welfare of all residents. This failure of the RN led to a medical emergency which resulted in significant harm that could have resulted in death, serious medical impairment or disability of a resident. THIS IS A REPEAT DEFICIENCY THAT WAS	A 604		

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A 604	Continued From page 46 CITED DURING THE SURVEY COMPLETED MAY 26, 2021. Findings: EI#3 who was responsible for the staffing schedule, failed to ensure the facility was staffed at all times by at least the minimum required number of staff. (Deficiency 401) EI#3 failed to complete required assessments and also answered assessment questions falsely. (Deficiency 405) EI#3 failed to ensure a physician's order was followed to keep hazardous items from a resident (which the resident used to attempt suicide). Also, EI#3 forged the Medical Director's signature on a prescription for an antipsychotic medication. (Deficiency 601) EI#3 did not ensure the accuracy of the pre-admission assessment and completion of other required assessments which resulted in the admission of a resident with suicidal and homicidal ideations, who attempted suicide after less than three days at the facility. (Deficiency 604) EI#3 did not ensure general observation and health supervision of a resident that attempted suicide which resulted in harm. (Deficiency 605) EI#3 requested emergency behavioral symptoms be treated with an anti-anxiety medication. This was for a resident that was admitted directly from a hospital stay that provided around the clock one-on-one sitters for suicide watch. (Deficiency 608) EI#3 did not develop a plan of care which contained interventions to meet the care and safety needs of a resident with suicidal ideations, homicidal ideations and safety risks identified in the initial physician's medical examination. (Deficiency 611)	A 604		

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A 604	Continued From page 47 EI#3 admitted a resident who had been admitted to the hospital for suicidal and homicidal ideations and who was on suicide watch with around the clock one-on-one sitters. This indicated the resident was at risk for harm to self or others and did not meet admission criteria requirements for a SCALF. (Deficiency 620) Each of these failures were the result of the direct action or inaction of EI#3, RN. These failures resulted in significant harm for one resident and placed all 17 residents at significant risk of harm.	A 604		
A 605	420-5-20-.06 (3) (f) Care of Residents. (f) Observation. Each specialty care assisted living facility shall provide general observation and health supervision of the residents to identify changes in all residents' health conditions and physical abilities, and awareness of the need for medical attention or nursing services as the changes develop. Whenever a resident requires medical attention, nursing services, or changes in personal care and assistance with activities of daily living provided by the facility, the facility shall arrange for or assist the residents in obtaining necessary services. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to utilize general observation and health	A 605		

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A 605	Continued From page 48 supervision of a resident who required medical attention. THIS IS A REPEAT DEFICIENCY THAT WAS CITED DURING THE SURVEY COMPLETED MAY 26, 2021. Findings: On November 6, 2025, the Alabama Department of Public Health received a facility reported incident which alleged a resident of the facility had taken medications that belonged to another resident and said, "I want to die." An investigation of care survey was conducted to ascertain the care and safety of residents. RI#1 was admitted to the facility on November 3, 2025. Refer to deficiencies 302, 405, 504, 508, 601, 604, 607, 608, 611, 612, 615 and 620 for additional information regarding RI#1. Facility staff reports were as follows. On the morning of November 12, 2025, EI#8 a caregiver, reported she worked November 4 - 5, 2025 with RI#1. EI#8 said RI#1 had sundowners real bad and that RI#1 tried to elope by attempting to follow EI#8 out the door. EI#8 said these behaviors began the first day RI#1 was admitted. EI#8 would notify EI#4 and they would give RI#1 coffee to try to bribe RI#1 not to follow them out. EI#8 said RI#1 was a wanderer and there was no activity plan in place for RI#1. Later on the morning of November 12, 2025, EI#9, a caregiver, reported RI#1 was hard to redirect. EI#9 reported when she arrived at the facility on November 6, 2025, she could tell RI#1 had not slept because he/she was still in the clothes and shoes from the day before. RI#1 was	A 605		

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A 605	Continued From page 49	A 605		

irate, walking in and out of the nurses room, pulling fire extinguishers off of the wall, and trying to elope. EI#9 said RI#1 was really worked up, cursing, talking loud and the other residents looked scared. EI#9 witnessed RI#1 going into other residents' rooms. EI#9 said RI#1 even tried to come into the room where EI#9 was sitting with another resident. EI#9 said there was no activity plan for RI#1's wandering. EI#9 added RI#1 was like this from the time of admission.

On the afternoon of November 12, 2025, EI#14 said during one shift RI#1 was angry and tried to use a fire extinguisher to hit staff. EI#14 said she notified EI#3.

On the afternoon of November 12, 2025, EI#15, an LPN, who worked the 3:00 PM - 11:00 PM shift on the evening before RI#1 attempted suicide, was interviewed. EI#15 said it was the first time she had met RI#1. EI#15 said RI#1 screamed and yelled the whole shift. RI#1 used his/her walker to walk up and down the halls, went in other residents' rooms calling for his/her spouse, turning lights on and waking residents up. EI#15 said residents were standing in the hall wondering what was going on. RI#1 was also setting the door alarms off. EI#15 agreed this was not appropriate behavior. EI#15 said she sent a text to EI#3, RN, and EI#3 said there was nothing they could do except to call the spouse. The spouse was unable to help and EI#15 said RI#1 was being disruptive. EI#15 said she was told RI#1 was at the facility after a hospital stay for a fall. EI#15 said staff use the care plan to provide care but the care plan did not match who RI#1 was. EI#15 said she was never made aware that 911 was called for suicidal and homicidal ideations prior to admission but RI#1's spouse said RI#1 had attacked them at home. EI#15 was

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A 605	Continued From page 50	A 605		

asked if RI#1 was appropriate for a SCALF and she said no. EI#15 added the facility does not have one-on-one sitters much less provide suicide watch. EI#15 said she sent EI#3 a text to let her know RI#1's spouse was unable to help with RI#1, but she got no response. When EI#15 was asked what precautions were put in place to keep hazardous items from RI#1, EI#15 said staff was not told about that and they just tried to keep RI#1 safe from himself/herself. EI#15 was shown the H&P by the surveyor. Then EI#15 said she could not have kept RI#1 safe. EI#15 acknowledged the unsecured Propranolol was hazardous to RI#1 and that the doctor's order was not followed. EI#15 added RI#1 required skilled nursing care or even care beyond that.

Later on the afternoon of November 12, 2025, when EI#5 was asked who she reported the suicide threat to, EI#5 named EI#4 who responded they would just keep an eye on RI#1. After EI#5 knew RI#1 had overdosed she told EI#4 to call 911, but EI#4 did not call 911 at that time.

On the morning of November 13, 2025, EI#4 reported when she was made aware that RI#1 had overdosed she should have called 911 immediately but was in shock.

The facility admitted a resident that was not appropriate based on past behaviors and current suicide watch. From day one of admission, RI#1 exhibited unmanageable behaviors that exceeded the level of care facility staff was trained to provide and the facility was licensed to provide. EI#3, RN, failed to act on the reports made by staff to keep the resident safe. The facility failed to arrange for necessary services for RI#1.

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A 607	Continued From page 51	A 607		
A 607	420-5-20-.06 (3) (h) (i) Care of Residents. h) Care During Emergency or Illness. The resident's attending physician, or a backup physician or facility Medical Director, if the attending physician is unavailable, shall be promptly called at the onset of an illness or in case of accident or injury to a resident. In case of a medical emergency that could result in death, serious medical impairment, or disability to a resident, the local EMS system shall be activated by calling 911 or other emergency local telephone numbers. (i) A specialty care assisted living facility shall maintain the following telephone numbers, properly identified, and posted in a prominent location readily accessible and known to all staff members: 1. Each resident's attending physician, and the facility's backup physician or Medical Director. 2. 911, or the local emergency telephone number if the community is not served by a 911 telephone service. This Rule is not met as evidenced by: Based on record review and interview, facility staff delayed notification of 911 during a medical emergency that could have resulted in death, serious medical impairment or disability of the resident.	A 607		

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A 607	Continued From page 52 Findings: RI#1 was admitted to the facility on November 3, 2025. Refer to deficiencies 302, 405, 504, 508, 601, 604, 605, 608, 611, 612, 615 and 620 for additional information regarding RI#1. On November 6, 2025, RI#1 ingested a large number of pills from a bottle he/she found in another residents room. RI#1 told staff he/she wanted to kill himself/herself. Review of the ambulance run report for November 6, 2025, for RI#1's medical emergency revealed, "... Call Date/Time 11/6/2025 08:15 ... Unit Notified by Dispatch Date/Time 11/6/2025 08:16 Unit En Route Date/Time 11/6/2025 08:18 ... Unit Arrived on Scene Date/Time 11/6/2025 08:25 ... Dispatch Complaint Overdose/Poisoning/Ingestion ... Dispatch Delay None/No Delay Response Delay None/No Delay Scene Delay None/No Delay Transport Delay None/No Delay ... Provider's Primary Impression Poisoning by unspecified drugs, medications and biological substances, intentional self-harm, ... Date/Time of Symptom Onset 11/6/2025 08:06 Complaints Overdose Duration of complaint 30 Time Units of Duration of Complaint Minutes ... Barriers to Patient Care Unconscious ... Vitals SBP (Systolic Blood Pressure) 56 DBP (Diastolic Blood Pressure) 37 ... Narrative Section Dispatch ... report of a resident who had reportedly overdosed. Arrival on Scene Upon arrival, (Name of responding unit) located a (male/female) patient seated on the toilet under the supervision of the facility's nursing staff. Nursing staff stated that the patient ingested approximately three-quarters of a bottle of Propranolol. It was undetermined how the patient obtained access to	A 607		

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the medication, given (his/her) secure memory care environment. ... Transport and Transfer of Care ... The patients condition remained critical but stable throughout transport. ..."
Note: Date/Time of Symptom onset was 8:06 AM, 911 was not called until 8:15 AM.

Interview with EI#5
On the afternoon of November 12, 2025, EI#5, was asked about RI#1 on the day of the incident. EI#5 said she came to work November 6, 2025, at 7:00 AM and was making rounds. When EI#5 went to RI#1's room, RI#1 was getting up out of bed. When EI#5 and RI#1 got into the hallway, RI#1 told EI#5 he/she was not eating any breakfast and wanted to kill himself/herself. EI#5 said she told RI#1, no he/she didn't and RI#1 asked why not. EI#5 then told RI#1 because she loved RI#1. When asked who she (EI#5) reported the verbal expression of suicide to, EI#5 named EI#4, the LPN on duty. EI#5 said EI#4 responded back they would just keep an eye on RI#1. EI#5 said RI#1 agreed to sit and drink some coffee at that time. EI#5 left the room to check on another resident. When EI#5 returned, she noticed RI#1 was no longer in the dining room. EI#5 was told RI#1 had went to the restroom. She (EI#5) immediately went to check on RI#1. She found RI#1 outside the nurses' station. EI#5 asked RI#1 where he/she had been and noticed a pill bottle in RI#1's hand. EI#5 said RI#1 claimed he/she had taken about two-thirds of the pills in an attempt to kill himself/herself. When EI#5 took the pill bottle from RI#1, she observed what appeared to be "pill" dust around RI#1's mouth. EI#5, caregiver, then told EI#4, LPN, who was standing nearby, that RI#1 had taken the medication and an ambulance needed to be called.
When EI#5 was asked how EI#4 responded, EI#5 said EI#4 asked RI#2 (whose room the

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medication had been taken from) if there were pills in the bottle. RI#2 said there were. RI#2 was eating breakfast in the adjacent dining room at the time. EI#5 then observed EI#4 make a telephone call and assumed EI#4 had called 911 and EI#3. Note: The call EI#5 saw EI#4 make was to EI#3. See EI#4 interview below.
EI#5 said RI#1 was repeatedly saying, "I took them" (the pills) and then started to walk toward his/her room. EI#4 followed RI#1 and EI#5 after she served two plates of food in the dining room. EI#5 said she and EI#4 assisted RI#1 to the toilet and she (EI#5) stayed with RI#1 while EI#4 went to call for an ambulance. EI#5 said RI#1's body went stiff and leaned sideways. RI#1 was sweating profusely and foaming at the mouth. EI#5 tried to compress RI#1's chest and kept telling RI#1 to stay with her, that help was on the way. EI#5 said RI#1 was still seated on the toilet when she (EI#5) tried to press his/her left upper chest. EI#5 reported RI#1 was non-responsive.

Interview with EI#4, LPN
On the morning of November 13, 2025, EI#4 reported that RI#1 asked to go to the restroom about 7:30 AM on the morning of November 6, 2025. EI#4 said she and EI#5 were assisting another resident while RI#1 went to the restroom. After assisting the other resident to the dining room, EI#5 went looking for RI#1. EI#5 found RI#1 with a pill bottle in his/her hand. EI#4 asked RI#1 if he/she had taken the pills and RI#1 said yes. EI#4 asked RI#1 why he/she would take someone else's medicine. RI#1 answered EI#4 because I want to die. EI#4 then said to EI#5 "Oh my God, is this real, oh! I couldn't believe (RI#1) did (that)." EI#4 said then RI#1 wanted some coffee so she (EI#4) went to the dining room to get coffee. RI#1 sat in the dining room for only a minute or two then RI#1 said he/she wanted to go

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A 607	Continued From page 55	A 607		

to the bathroom. RI#1 got his/her walker and headed to his/her room to the bathroom. EI#4 followed RI#1. EI#4 and EI#5 assisted RI#1 to the toilet and that was when RI#1 started to look weak. EI#4 said, EI#5 stayed with RI#1 so she (EI#4) could go and call the ambulance. EI#4 added she had tried to call EI#3, RN, earlier but it went straight to voicemail. She couldn't get EI#3 on the phone. EI#4 was asked why she did not call 911 immediately when she was told RI#1 had ingested the medication. EI#4 said, "Because I did not want to leave (him/her) alone, (I) didn't want to leave the resident alone." EI#4 was asked when she saw that RI#1 had the bottle in his/her hand and RI#1 told her he/she took the pills and said she wanted to die, why did she not call 911 immediately instead of agreeing to get the resident some coffee. EI#4 answered, "Yea, I should have, I don't know. I just was in shock that (he/she) did that. I think I was in shock that (he/she) had took so many pills. I really was just in shock myself." When asked about emergency training, EI#4 said she was trained to call 911, she knows to do that, but EI#4 believed she was in shock herself. EI#4 was asked what she did after RI#1 told her he/she had taken the pills and wanted to die. EI#4 responded she was trying to count the pills in the bottle and see how many RI#1 had taken. EI#4 confirmed RI#1 sat in the dining room for a minute or two then EI#4 let RI#1 go to RI#1's room to the bathroom. Finally, after she saw RI#1 was not well, she called 911. EI#4 said, "yes", that was correct.

On the afternoon of November 13, 2025, EI#3 said 911 should be notified immediately if a resident had overdosed. When asked what the concern was of not calling 911 after a resident overdoses, EI#3 said, "It could be a tragic outcome." Later that afternoon EI#2 said 911

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A 607	Continued From page 56 should be called immediately if a resident overdoses.	A 607		
A 608	420-5-20-.06 (3) (j) Care of Residents (j) Mechanical Restraint and Seclusion. No form of physical restraint or seclusion shall be applied to residents of a specialty care assisted living facility except in extreme emergency situations when the resident presents a danger of harm to himself or herself or to other residents. In such an event, the facility shall use the least restrictive intervention that will be effective to protect residents, immediately notify the resident's physician and sponsor, and appropriate treatment, transfer to an appropriate health care facility, or both shall be provided without any avoidable delay. In no event shall emergency behavioral symptoms of residents be treated with sedative medications, anti-psychotic medications, anti-anxiety medications, or other psychoactive medications in a specialty care assisted living facility. This Rule is not met as evidenced by: Based on record review and interview, the facility treated a resident who exhibited emergency behavioral symptoms with an anti-anxiety medication. Findings: RI#1 was admitted to the facility on November 3, 2025. Refer to deficiencies 302, 405, 504, 508, 601, 604, 605, 607, 611, 612, 615 and 620 for additional information regarding RI#1. On November 3, 2025, EI#3 wrote a verbal order for,	A 608		

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A 608	Continued From page 57 "... Haloperidol 0.5 mg tab (tablet) Give 1 tab po (by mouth) Q(every)6h(hours) prn (as needed) Agitation ..." On November 5, 2025, at 4:00 PM, EI#3 administered a dose of Haloperidol to RI#1. On the morning of November 13, 2025, EI#10 was asked if he thought Haloperidol was appropriate to prescribe for behaviors on the first day of admission. EI#10 said no and that the signature on the order was not his. The prescription had been forged by EI#3 by her own admission. On the afternoon of November 13, 2025, EI#3 said she was the person responsible for ensuring emergency behavior symptoms were not treated with sedative, anti-psychotic or anti-anxiety medications or other psychoactive medications. When asked why Haldol was administered for an emergency behavior, EI#3 said she did not know it was not okay. Later that afternoon EI#2 said it was EI#3's responsibility to ensure emergency behavior symptoms were not treated with anti-psychotic medications.	A 608		
A 611	420-5-20-.06 (4) (a) (b) Care of Residents. (4) Personal Care and Services. The facility shall provide care and services consistent with community standards. (a) Portions of residents' records necessary for staff to provide care, including the plans of care and relevant portions of the medical examination records and admission records, shall be accessible to the direct care staff at all times. (b) Plan of Care. The RN shall develop written plans of care for each resident prior to or	A 611		

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A 611	Continued From page 58 at the time of admission. The plans of care shall be based on resident's assessments, diagnoses, and recommendations of the resident's physician. The plan of care shall be developed in cooperation with the resident, if appropriate, and the sponsor. The RN shall identify resident care problem areas and formulate written interventions to address those problems. The RN shall evaluate the implementation of the interventions and the resident's response to the interventions and modify the plan of care as necessary. 1. The plan shall at all times reflect the current condition of the resident. All entries on the plan of care shall be accurately dated. In addition to other items that may be required by the facility's own policies and procedures, the plan of care shall contain the following: 2. A listing of the resident's individual needs or problems that require intervention by the facility. 3. A listing of interventions provided by the facility to address the resident's identified needs or problems. 4. A copy of any outside provider's certification and plan of care, such as the current Home Health Certification and Plan of Care for each resident receiving care from an outside provider. 5. Activities of Daily Living. Residents of a specialty care assisted living facility shall be assisted and encouraged to maintain a clean, well-kept personal appearance. Each facility shall provide all needed assistance with activities of daily living to each resident.	A 611		

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A 611	Continued From page 59 (i) Bathing. Residents shall be offered a bath or partial bath or shall be assisted with a bath or partial bath daily, and more often when necessary or requested. (ii) Oral Hygiene. Residents shall be assisted with oral hygiene to keep mouth, teeth, or dentures clean. Measures shall be used to prevent dry, cracked lips. (iii) Hair. Residents' hair shall be kept clean, neat, and well groomed. (iv) Manicure. Fingernails and toenails shall be kept clean and trimmed. (v) Shaving. Men shall be assisted with shaving or shaved as necessary to keep them clean and well groomed. (vi) Personal Safety. Residents shall be provided assistance with personal safety. 6. As changes in medication and personal services become necessary, the plan of care shall be promptly updated and all changes shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to develop a plan of care which contained interventions to meet the care and safety needs of a resident with suicidal ideations, homicidal ideations and safety risks identified in the initial physician's medical examination.	A 611		

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A 611	Continued From page 60 THIS IS A REPEAT DEFICIENCY THAT WAS CITED DURING THE SURVEY COMPLETED APRIL 3, 2025, MAY 26, 2021 AND APRIL 18, 2019. Findings: RI#1 was admitted to the facility on November 3, 2025. Refer to deficiencies 302, 405, 504, 508, 601, 604, 605, 607, 608, 611, 612, 615 and 620 for additional information regarding RI#1. A review of the facility record revealed RI#1's care plan did not address behaviors nor that RI#1 had been hospitalized for suicidal and homicidal ideations. RI#1's physician's medical exam documented, "... Behaviors: redirection/provide safety ..." Furthermore, the "PERSONAL SAFETY" portion of the care plan did not address the physician's directive to "... keep away from hazardous items ..." as documented in the physician's medical exam. The care plan was a generic plan that was not specific to RI#1's crucial and specific care and safety needs On the morning of November 12, 2025, EI#8 reported that she worked the first two days that RI#1 was at the facility. EI#8 reported RI#1 had sundowner's (wandering behavior) real bad and tried to elope by trying to follow EI#8 out of the door. EI#8 said this began the day RI#1 was admitted and she reported it to EI#4 who helped staff to leave by distracting RI#1 with coffee. EI#8 said RI#1 was a wanderer and EI#3 witnessed it or should have from her office (that opens into the dining room). On the morning of November 12, 2025, EI#9 reported RI#1 was hard to re-direct, did not want to use his/her walker or rollator, would get irate, walked in and out of the nurses' room, pulled fire	A 611		

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A 611	Continued From page 61	A 611		

extinguishers off of the wall, tried to elope, cursed loud and scared the other residents. EI#9 added RI#1 would go in and out of residents' rooms as she witnessed when she was sitting with a resident and RI#1 came in the room. EI#9 reported RI#1 had these behaviors upon admission.

On the afternoon of November 12, 2025, EI#14 said RI#1 would get angry, take fire extinguishers off the wall to hit staff with and would exit seek. EI#14 added EI#3 was aware of these behaviors.

On the afternoon of November 12, 2025, EI#15 said staff usually use the care plan to provide care for residents, but RI#1's care plan did not match him/her.

Note: None of these issues that were present on admission were addressed in the plan of care. EI#3 did not identify EI#1's behaviors as a problem nor did she formulate interventions for staff to use when providing care.

Note: The plan of correction accepted on April 24, 2025, for the survey conducted on April 3, 2025, documented, "Effective immediately, the Memory Care Director, RN, (EI#3) will begin using the Care Plan Addendum template to capture all pertinent medical information. ..."

On the afternoon of November 13, 2025, EI#3 said she was responsible for ensuring care plans were developed to address resident needs including behaviors. When asked why that was not done, EI#3 said she usually care planned prescriptions and diagnoses. When asked why she did not care plan the physician's specific order to keep RI#1 away from hazardous items, EI#3 said, "I just didn't do it." Later that afternoon

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A 611	Continued From page 62 EI#2 said it was EI#3's responsibility to ensure care plans were developed to address resident needs including behaviors.	A 611		
A 612	420-5-20-.06 (4) (c) (d) (e) (f) Care of Residents. (c) Activity Program. There shall be an activity program designed to meet the individual needs of each resident. The facility shall maintain supplies and equipment as necessary to implement the activity programs. Every day the facility shall provide activities appropriate to residents with dementia. Residents who have wandering behaviors shall have a documented activity program to manage this behavior. (d) Pets residing at the facility or used in activity programs shall be in good health and shall have current vaccinations as required by law. Vaccination certificates, or copies of vaccination certificates, shall be kept on file at the facility to demonstrate compliance with this requirement. (e) Mail, Telegrams, and Other Communications. 1. Incoming mail, telegrams, and other written communications addressed to the resident shall be delivered to the resident unopened. Outgoing mail shall be promptly delivered to regular postal channels upon receipt from the resident. Residents shall be permitted to receive telephone calls at the facility in complete privacy. 2. Personnel of the facility shall assist residents with communications, such as writing letters or assisting with writing letters, or reading	A 612		

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A 612	Continued From page 63 mail out loud if requested to do so. (f) Appointments. Residents shall be assisted in making and keeping appointments. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop a specific activity program to meet the needs of a resident who had wandering behaviors. Findings: RI#1 was admitted to the facility on November 3, 2025. Refer to deficiencies 302, 405, 504, 508, 601, 604, 605, 607, 608, 611, 615 and 620 for additional information regarding RI#1. Staff reported they would bribe RI#1 with coffee so they could exit the facility without RI#1 trying to elope. Staff reported this behavior was present on admission. No activity care plan had been developed to address RI#1's wandering and exit seeking behavior. On the afternoon of November 13, 2025, EI#3 said she "guessed" she was responsible for ensuring an activity plan was in place for a resident with wandering behaviors. When asked why that was not done, EI#3 said, "That's new to me." When asked what was done for RI#1's exit seeking, EI#3 said redirecting. Later that afternoon EI#2 said EI#3 was responsible for ensuring an activity plan was in place for a resident with wandering behaviors.	A 612		

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A 613	Continued From page 64	A 613		
A 613	420-5-20-.06 (5) (a) (b) (c) (d) (e) Care of Residents. (5) Medications. (a) Medications, as defined in these rules, shall be prescribed specifically for the resident by an individual currently licensed to prescribe medications in Alabama. A currently licensed physician in good standing with the Medical Licensure Commission of any state may prescribe medications to a resident of an assisted living facility only during the initial physical examination. (b) A physician order is required for a resident to manage and have custody of his or her own medications. (c) A resident may have custody of and manage over the counter topical medications with the written approval of a physician. A physician order is not required for over the counter topical medications that are self-administered by residents and approved by the physician for resident possession. (d) Medication administration, as defined in these rules, shall be conducted only by a physician or an RN or LPN. An RN or LPN shall administer medications to residents in the specialty care assisted living facility only in accordance with physician orders and the Nurse Practice Act. (e) A current copy of A Short Practical Guide for Psychotropic Medications in Dementia Patients or the equivalent shall be in each specialty care assisted living facility as a	A 613		

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A 613	Continued From page 65 reference guide. This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to obtain a physician's order for residents to manage or have custody of their own medications. Findings: On November 6, 2025, the Alabama Department of Public Health received a facility self reported incident which alleged a resident of the facility had taken medications that belonged to another resident and expressed suicidal ideations. An investigation of care survey was conducted to ascertain the care and safety of residents. On the morning of November 11, 2025, an initial tour of the facility was conducted with EI#3 focusing on medications in the rooms, available to residents. The following medications were observed in residents' rooms; Pataday eye drops, Refresh over-the-counter (OTC) eye drops, OTC antibiotic ointment, OTC nasal spray, Campho Phenique, Aspercreme with Lidocaine, Estradiol cream, Miconazole 2% topical prescription powder, Nystatin prescription powder and zinc oxide prescription paste. On the afternoon of November 12, 2025, EI#3 was asked to provide the physicians' orders for the medications found in residents' rooms. EI#3 said there was no need to look in the charts because there were no orders for residents to have those medications in	A 613		

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A 613	Continued From page 66 their rooms. On the morning of November 6, 2025, RI#1 wandered into RI#2's room, found a bottle of Propranolol and proceeded to ingest a large amount of the medication (60-70 pills). RI#1 was subsequently hospitalized after this suicide attempt. On the afternoon of November 13, 2025, EI#3 said she was responsible for ensuring bottles of medication were not maintained in residents' custody without a physician's order. When asked why that was not done, EI#3 said, regarding the bottle of Propranolol, RI#2's spouse brought the medication to RI#2 the evening before RI#1 attempted suicide with the Propranolol found in RI#2's room. EI#3 said she advised RI#2's spouse not to bring medications in, but to bring the order to the facility and the nurses would administer the medication. When asked about the medications observed in residents' rooms during the tour with the surveyor, EI#3 said she overlooked them. Later, on the afternoon of November 13, 2025, EI#2 said EI#3 was responsible for ensuring physicians' orders were in place for medications in residents' custody.	A 613		
A 615	420-5-20-.06 (5) (h) Care of Residents. (5) Medications. (h) All medications administered to residents in a specialty care assisted living facility, shall be contemporaneously recorded on a standard medication administration record. "Contemporaneously recorded" means recorded at the same time or immediately after medications are administered. The medication	A 615		

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A 615	Continued From page 67 administration record shall include at least the following: 1. The name of the resident to whom the medication was administered. 2. The name of the medication administered. 3. The dosage of the medication administered. 4. The method of administration. 5. The site of injection or application, if the medication was injected or applied. 6. The date and time of the medication administration or assisted. 7. Any adverse reaction to the medication. 8. The printed name, initials, and written signature of the individual administering the medication or assisting the resident with self-administration of the medication. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure medications were documented contemporaneously on the Medication Administration Records (MAR). Findings: RI#1 was admitted to the facility on November 3,	A 615		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 615	Continued From page 68 2025. Refer to deficiencies 302, 405, 504, 508, 601, 604, 605, 607, 608, 611, 612 and 620 for additional information regarding RI#1. On the afternoon of November 13, 2025, RI#1's Haldol 0.5 MG was observed to have two missing pills. Review of RI#1's MAR revealed, no documentation of any Haldol doses having been administered. EI#3 investigated the missing pills and reported one pill was offered to RI#1 which was refused, though not documented. EI#3 said she administered the other pill at 4:00 PM on November 5, 2025. EI#3 did not document RI#1 had received the pill on November 5, 2025, nor did EI#3 document the effectiveness of the medication. EI#3 agreed medications should be documented at the time they are administered.	A 615		
A 619	420-5-20-.06 (8) Care of Residents. (8) Storage of Medical Supplies. (a) First Aid Supplies. First aid supplies shall be maintained in a place readily accessible to persons providing personal care and services in the specialty care assisted living facility. These supplies will be inspected at least annually to ensure their usability. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure stored medical supplies were inspected annually to ensure their usability. Findings:	A 619		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	P4903	A. BUILDING: _____ B. WING _____	11/13/2025

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A 619	Continued From page 69 On the morning of November 11, 2025, an observation was made with EI#3 of Covid test kits that had expiration dates of November 11, 2024. EI#3 said the test kits should have been discarded. EI#3 said she was not sure what kits were used during the latest Covid outbreak in August. On the afternoon of November 13, 2025, EI#3 said she was responsible for ensuring Covid tests were not expired. When asked why it had not been done, EI#3 said they had fallen behind her desk and should have been thrown away.	A 619		
A 620	420-5-20-.06 (9) (a) Care of Residents (9) Admission and Retention of Residents. Residents admitted to and retained in specialty care assisted living facilities must meet all eligibility and continued stay requirements specified in these rules. (a) Admission. 1. A specialty care assisted living facility shall not admit any individual who: (i) Is receiving or requires skilled nursing care. (ii) Has a wound that requires care beyond basic first aid. (iii) Has unmanageable behaviors or behaviors that may be dangerous to themselves or others. (iv) Has a PSMS score greater than 23 or a score of five in feeding, dressing, grooming,	A 620		

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A 620	Continued From page 70 bathing, or a score of four or five in physical ambulation. (v) Is receiving or in need of hospice services. (vi) Is diagnosed with an active acute infectious pulmonary disease, such as influenza or active tuberculosis, or with other diseases capable of transmission to other individuals through normal person-to-person contact. This Rule is not met as evidenced by: Based on interview and record review, the facility admitted a resident who did not meet eligibility requirements for a SCALF. Findings: Review of resident records on November 11-13, 2025 revealed RI#1 was admitted to the facility on November 3, 2025. Refer to deficiencies 302, 405, 504, 508, 601, 604, 605, 607, 608, 611, 612 and 615 for additional information regarding RI#1. This admission came after RI#1 had been taken by police to a local hospital for suicidal and homicidal ideations. Prior to discharge from the hospital, RI#1 had one-on-one sitters continuously for suicide watch. On the afternoon of November 11, 2025, EI#2 provided the medical record for RI#1 and was asked to review the Physician's Medical Exam. EI#2 read the portion of the exam that documented RI#1's behaviors and the need to avoid hazardous items. EI#2 said "We put	A 620		

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A 620	Continued From page 71 (him/her) at risk. We should have never admitted (him/her)." EI#2 added she should have caught it. On the afternoon of November 12, 2025, EI#12, the interim Chief Nursing Officer for the local hospital, said RI#1 was brought in to the hospital by police and subsequently admitted. EI#12 reported RI#1 was unable to go back home with family. EI#12 acknowledged RI#1 had a one-on-one sitter until discharge which was customary for patients on suicide watch. On the morning of November 13, 2025, EI#10, the Medical Director, was asked about RI#1's admission. EI#10 reported he was told RI#1 had unmanageable behaviors related to senile dementia. EI#10 said he was not given any details about the behaviors or why RI#1 had been admitted to the hospital. EI#10 said he was not told about the one-on-one sitters for suicide watch. EI#10 also said EI#3 did not show him RI#1's complete Physician's Medical Examination including pages that documented RI#1's specific behaviors. EI#10 said if he had known RI#1 was on suicide watch, he would have said RI#1 was not appropriate for the facility. On the afternoon of November 13, 2025, EI#3 said she was responsible for ensuring admissions were appropriate for the SCALF. When asked why that was not done, EI#3 said she did not dig deep enough or ask enough questions and she did not get the H&P from the hospital. EI#3 was asked if RI#1 was appropriate for admission. She said no. EI#3 added if she had gotten the H&P she would not have admitted RI#1 to the facility. Later that afternoon of November 13, 2025, EI#2 said she and EI#3 were responsible for ensuring admissions were appropriate and she (EI#2) should have caught it.	A 620		

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A 620	Continued From page 72 THERESA HARRISON, REGISTERED NURSE	A 620		